CLARIFY THE TERMS AND CONDITIONS OF EMPLOYMENT OF THE DIRECTOR OF A LOCAL MANAGEMENT ENTITY

SECTION 6.20.(a) G.S. 122C-121 reads as rewritten:

"**§ 122C-121. Area director.**

(a) The area director is an employee of the area ~~board~~ board, shall serve at the pleasure of the board, and shall be appointed in accordance with G.S. 122C-117(7). ~~The area director is the administrative head of the area program.~~ As used in this subsection, "employee" means an individual and does not include a corporation, a partnership, a limited liability corporation, or any other business association.

(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. An area board may request an adjustment to the salary ranges under G.S. 126-9(b). The request shall include specific information supporting the need for the adjustment, including comparative salary and patient caseload data for other LMEs, and shall also include the specific amount the area board proposes to pay the director. The area board shall not request a salary adjustment that is more than ten percent (10%) above the normal allowable salary range as determined by the State Personnel Commission.

(a2) The area board shall not provide the director with any benefits that are not also provided by the area board to all permanent employees of the area program. The director shall be reimbursed only for allowable employment-related expenses at the same rate and in the same manner as other employees of the area program.

(b) The area board shall evaluate annually the area director for performance based on criteria established by the Secretary and the area board. In conducting the evaluation, the area board shall consider comments from the board of county commissioners.

(c) The area director is the administrative head of the area program. In addition to the duties under G.S. 122C-111, the area director shall:

(1) ~~Appoint and supervise~~ Appoint, supervise, and terminate area program staff.
(2) Administer area authority services.
(3) Develop the budget of the area authority for review by the area board.
(4) Provide information and advice to the board of county commissioners through the county manager.
(5) Act as liaison between the area authority and the Department.

(d) Except when specifically waived by the Secretary, the area director shall meet all the following minimum qualifications:

(1) Masters degree.
(2) Related experience.
(3) Management experience.
(4) Any other qualifications required under G.S. 122C-120.1."

SECTION 6.20.(b) This section is effective when this act becomes law, and G.S. 122C-121(a1) and (a2), as enacted in subsection (a) of this section, applies to salary plans submitted and contracts entered into, extended, modified, or renewed on or after that date.

CONTINUATION REVIEW OF CERTAIN FUNDS, PROGRAMS, AND DIVISIONS

SECTION 6.21.(a) No later than February 1, 2008, the Administrative Office of the Courts shall provide a written report to the Appropriations Committees of the Senate and House of Representatives on the following funds, programs, or divisions:

(1) Association of Clerks of Superior Court.
(2) The Conference of District Attorneys.

The report shall include all of the information listed in subsection (g) of this section.

prescription drugs through the use of personal data assistance (PDA) technology. The Division may designate CCNC through the Office of Rural Health and Community Care as the lead program to implement this section and shall assist CCNC by providing cost containment funds to purchase PDAs, connectivity, and software, and for other related costs.

EFFECTIVE DATE OF CHANGES TO MEDICAID ESTATE RECOVERY PLAN

SECTION 10.42.(a) Section 10.21C(c) of S.L. 2005-276, as amended by Section 16 of S.L. 2005-345, and further amended by Section 10.9B of S.L. 2006-66, and as further amended by Section 10 of S.L. 2007-145, reads as rewritten:

"**SECTION 10.21C.(c)** This section becomes effective ~~August 1, 2007,~~July 1, 2008, and applies to recipients of medical assistance on or after that date."

SECTION 10.42.(b) In the event the effective date of Section 10.21C(c) of S.L. 2005-276 made applicable under subsection (a) of this section conflicts with the effective date of a provision in House Bill 1537, enacted by the 2007 General Assembly, pertaining to Medicaid Estate Recovery, the effective date contained in House Bill 1537 shall apply.

EXTEND IMPLEMENTATION OF COMMUNITY ALTERNATIVES PROGRAMS REIMBURSEMENT SYSTEM

SECTION 10.44. Full implementation for the Community Alternatives Programs reimbursement system shall be not later than twelve months after the date on which the replacement Medicaid Management Information System becomes operational and stabilized.

FAMILIES PAY PART OF THE COST OF SERVICES UNDER THE CAP-MR/DD PROGRAM AND THE CAP-CHILDREN'S PROGRAM BASED ON FAMILY INCOME

SECTION 10.45.(a) Subject to approval from the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services, Division of Medical Assistance, shall develop a schedule of cost-sharing requirements for families of children with incomes above the Medicaid allowable limit to share in the costs of their child's Medicaid expenses under the CAP-MR/DD (Community Alternatives Program for Mental Retardation and Developmentally Disabled) Program and the CAP-C (Community Alternatives Program for Children). The cost-sharing amounts shall be based on a sliding scale of family income and shall take into account the impact on families with more than one child in the CAP programs. In developing the schedule, the Department shall also take into consideration how other states have implemented cost-sharing in their CAP programs. The Division of Medical Assistance may establish monthly deductibles as a means of implementing this cost-sharing. The Department shall provide for at least one public hearing and other opportunities for individuals to comment on the imposition of cost-sharing under the CAP program. Not later than March 1, 2008, the Department shall report on the cost-sharing requirements to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs, and to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division. The report shall include a summary of comments the Department has received at the public hearing required under this subsection, and shall also indicate any barriers to implementing the cost-sharing schedule.

SECTION 10.45.(b) This section becomes effective July 1, 2008, for children enrolled in CAP-MR/DD or CAP-C on and after that date. For currently enrolled CAP-MR/DD and CAP-C recipients, this section becomes effective at the recipient's first certification period following July 1, 2008.

SECTION 10.45.(c) The Division of Medical Assistance shall report on savings realized due to the cost-sharing implemented pursuant to this section. Savings realized from the implementation of cost-sharing shall remain in the CAP-MR/DD and CAP-C programs, as applicable, and shall be used to fund additional CAP-MR/DD and CAP-C slots. The Department shall submit the report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on or before March 1, 2009.

CONTINUE EFFORTS TO EXPAND COMMUNITY CARE AND IMPROVE QUALITY OF CARE FOR AGED, BLIND, AND DISABLED MEDICAID RECIPIENTS

SECTION 10.46.(a) The Department of Health and Human Services shall continue its efforts to expand the scope of Community Care of NC care management model to recipients of Medicaid and dually eligible individuals with a chronic condition and long-term care needs. In expanding the scope, the Department shall focus on the Aged, Blind, and Disabled, and CAP-DA populations for improvement in management, cost-effectiveness, and local coordination of services through Community Care of NC and in collaboration with local providers of care. The Department shall target personal care services, private duty nursing, home health, durable medical equipment, ancillary professional services, specialty care, residential services, including skilled nursing facilities, home infusion therapy, pharmacy, and other services determined target-worthy by the Department. The Department shall pilot communitywide initiatives and shall expand statewide successful models. The initiatives may include one or more pilot projects to control costs and improve quality of care for the Aged, Blind, and Disabled recipients of Medicaid.

SECTION 10.46.(b) The Department of Health and Human Services shall report not later than March 1, 2008, on the status of the implementation and findings of this pilot project with regard to improving the quality of care and controlling the cost of care for the Aged, Blind, and Disabled recipients of Medicaid. The report shall also address the Department's plans for expanding the pilot project and implementing the practices for all Aged, Blind, and Disabled Medicaid recipients in the State. The Department shall submit the report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

NC HEALTH CHOICE ENROLLMENT

SECTION 10.47. The Department of Health and Human Services may allow up to six percent (6%) enrollment growth annually over the prior fiscal year's enrollment in the NC Health Choice Program. The cap in enrollment growth shall be based on the month of highest Program enrollment in the prior fiscal year.

NC KIDS' CARE

SECTION 10.48.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Medical Assistance, the sum of three hundred sixty-eight thousand dollars ($368,000) for the 2007-2008 fiscal year shall be used by the Department of Health and Human Services to produce a report that identifies the most cost-efficient and cost-effective method for developing and implementing a program of comprehensive health care benefits within available funding for children ages 0 through 18 in families with annual incomes between two hundred percent (200%) and three hundred percent (300%) of the federal poverty level. The report shall consider and address the following:

(1) Congress' reauthorization of the State Children's Health Insurance Program (SCHIP) with respect to:

Legislative Commission on Governmental Operations, and the Fiscal Research Division. The Department shall submit its final report not later than February 1, 2008. It is the intent of the General Assembly to review the Department's recommendations before the Department implements a program to expand access to health insurance to children above two hundred percent (200%) of the federal poverty level effective July 1, 2008, or upon approval of all required federal waivers, whichever occurs later.

SECTION 10.48.(c) Of the funds appropriated in this act to the Department of Health and Human Services, the sum of seven million dollars ($7,000,000) for the 2008-2009 fiscal year shall be used to implement a program to expand access to health insurance to children above two hundred percent (200%) of the federal poverty level effective July 1, 2008.

BUILD COMMUNITY INFRASTRUCTURE FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

INCREASE AVAILABILITY OF SUBSTANCE ABUSE TREATMENT.

SECTION 10.49.(a) Except as otherwise provided in this subsection, funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for regionally funded, locally hosted substance abuse services shall be allocated for the purpose of developing and enhancing the American Society of Addiction Medicine (ASAM) continuum of care at the community level. In coordination with local management entities, the Division shall develop and direct purchasing mechanisms to improve the availability of substance abuse services offered on a local, regional, and statewide basis in coordination with one or more local management entities. Of the funds allocated in this subsection for regionally funded, locally hosted substance abuse services, the sum of five hundred thousand dollars ($500,000) for the 2007-2008 fiscal year and the sum of seven hundred thousand dollars ($700,000) for the 2008-2009 fiscal year shall be allocated for residential substance abuse programs with a vocational component.

SECTION 10.49.(b) G.S. 122C-147.1 is amended by adding the following new subsection to read:

"(d1) Notwithstanding subsections (b) and (d) of this section, each area program shall determine whether to earn the funds for crisis services and funds for services to substance abuse clients in a purchase-for-service basis, under a grant, or some combination of the two. Area programs shall account for funds expended on a grant basis according to procedures required by the Secretary and in a manner that is similar to funds expended in a purchase-for-service basis."

SECTION 10.49.(c) Consistent with G.S. 122C-2, the General Assembly strongly encourages LMEs to use a portion of the funds appropriated for substance abuse treatment services to support prevention and education activities.

SECTION 10.49.(d) An LME may use up to one percent (1%) of funds allocated to it for substance abuse treatment services to provide nominal incentives for consumers who achieve specified treatment benchmarks, in accordance with the federal substance abuse and mental health services administration best practice model entitled Contingency Management.

SECTION 10.49.(e1) In providing treatment and services for adult offenders and increasing the number of TASC case managers, local management entities shall consult with TASC to improve offender access to substance abuse treatment and match evidence-based interventions to individual needs at each stage of substance abuse treatment. Special emphasis should be placed on intermediate punishment offenders, community punishment offenders at risk for revocation, and DOC releasees who have completed substance abuse treatment while in custody.

In addition to the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and

Substance Abuse Services to provide substance abuse services for adult offenders and to increase the number of TASC case managers, the Department shall allocate up to three hundred thousand dollars ($300,000) to Treatment Accountability for Safer Communities (TASC). These funds shall be allocated to TASC before funds are allocated to local management entities for mental health services, substance abuse services, and crisis services.

SECTION 10.49.(e2) In providing Drug Treatment Court services, local management entities shall consult with the local drug treatment court team and shall select a treatment provider that meets all provider qualification requirements and the drug treatment court's needs. A single treatment provider may be chosen for non-Medicaid-eligible participants only. A single provider may be chosen who can work with all of the non-Medicaid-eligible drug treatment court participants in a single group. During the 52-week Drug Treatment Court program, participants shall receive an array of treatment and after-care services that meets the participant's level of need, including step-down services that support continued recovery.

SECTION 10.49.(f) Within available State and county resources, local management entities shall work with county public health departments and county sheriffs to provide medical assessments and medication, if appropriate, for inmates housed in county jails who are suicidal, hallucinating, or delusional. LMEs shall also examine ways to provide additional treatment to persons who are determined to be psychotic, severely depressed, suicidal, or who have substance abuse disorders. To this end:

(1) The Department shall work with LMEs, county public health departments, and county sheriffs to develop a statewide standardized evidence-based screening instrument to be used when offenders are booked. The standardized screening tool shall be implemented by January 1, 2008.

(2) LMEs and county sheriffs shall work together to develop all of the following:

a. A designated LME employee who is responsible for screening the daily jail booking log for known mental health consumers.

b. Protocols for effective communication between the LME and the jail staff including collaborative development of medication management protocols between the jail staff and the mental health providers.

c. Training to help detention officers recognize signals of mental illness.

ADDITIONAL HOUSING ASSISTANCE.

SECTION 10.49.(g) The independent and supportive living apartments for persons with disabilities developed from funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the North Carolina Housing Finance Agency for that purpose shall be affordable to persons with incomes at the Supplemental Security Income (SSI) level. The Department shall maximize the number of subsidies that can be paid for with these funds by giving first priority to North Carolina Housing Agency-financed apartments, giving second priority to other publicly subsidized apartments, and third priority to market-rate apartments. Unless prohibited by the Fair Housing Act or other applicable federal law, in awarding funds for financing apartments, the Housing Finance Agency shall give first priority to those housing developments with an LME as the lead agency.

SECTION 10.49.(h1) The Department of Health and Human Services and the North Carolina Housing Finance Agency (NCHFA) shall work together to develop a plan for the most efficient and effective use of State resources in the financing and development of additional independent- and supportive-living apartments for

individuals with mental health, developmental or substance abuse disabilities. Not later than March 1, 2008, the Department and the NCHFA shall submit jointly an interim report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services ("Oversight Committee"). The interim report shall include how housing finance agencies and departments of health and human services in other states have worked together to address the housing needs of these populations and how other states have addressed disability specific housing. Not later than March 1, 2009, the Department and the NCHFA shall submit jointly a final report to the Oversight Committee. The final report shall take into consideration findings in the interim report and shall include strategies for addressing gaps in the housing continuum identified by the DHHS study of the housing needs of persons with mental illness in adult care homes, if the study is completed. The Department and the NCHFA shall also jointly report on the progress of the Housing 400 Initiative to the Oversight Committee not later than March 1, 2008.

SECTION 10.49.(h2) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, may transfer funds appropriated for operating cost subsidies for independent- and supportive-living apartments for individuals with disabilities to the North Carolina Housing Finance Agency (NCHFA) to be used for these purposes. If funds appropriated in this act for operating assistance for the independent supportive living apartments for people with disabilities exceed the amount necessary to finance those apartments for which funds were appropriated, then the excess funds may be used in each fiscal year to subsidize other apartments for individuals with disabilities that are affordable for individuals with income at the SSI level.

For the purposes of ensuring that State supported assisted housing is available to all disability groups, the NCHFA and the Department of Health and Human Services shall do the following:

(1) The NCHFA shall provide to the Division of Medical Assistance the identifying information of each resident that receives housing assistance in NCHFA properties because of the recipient's disability.

(2) The Department of Health and Human Services shall review the Medicaid database to determine which of these residents receives Medicaid and, of those, the type of disability of each Medicaid recipient for whom information was provided under subdivision (1) of this subsection.

(3) The Department of Health and Human Services shall report to the General Assembly the aggregate statewide total by type of disability. The types of disability for which aggregate data is reported shall be mental illness, developmental disability, physical disability, and the multiple combination of these types. The report shall ensure that individuals with multiple diagnoses are counted only one time for each aggregate report. The Department of Health and Human Services shall ensure that information reported does not include information that would identify or lead to the identity of a Medicaid recipient. The Department of Health and Human Services shall submit the report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division not later than May 1, 2008, and again not later than May 1, 2009.

(4) The reports required under subdivision (3) of this subsection shall include data on all housing units for people with disabilities financed with Housing Trust Fund funds appropriated for the 2006-2007 fiscal year or after.

Of the funds appropriated in this act to the Department of Health and Human Services for operating cost subsidies for independent- and supportive-living apartments for individuals with disabilities, not more than one hundred fifty thousand dollars ($150,000) may be used for administration of the subsidies and for evaluation and reporting requirements under this subsection.

SECTION 10.49.(i) The Department of Health and Human Services shall develop a "Transitional Residential Treatment Program" service definition to provide 24-hour residential treatment and rehabilitation for adults who have a pattern of difficult behaviors related to mental illness, which exceeds the capabilities of traditional community residential settings. Before implementing the definition and rate, the Department shall report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. Not later than March 1, 2008, the Department shall report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the implementation of this subsection.

SECTION 10.49.(j) The joint ad hoc subcommittee regarding the mentally ill in adult care homes convened by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the North Carolina Commission on Aging may continue to study and identify rules and laws that are necessary to regulate facilities that provide housing for adults with mental illness in the same location with adults without mental illness.

SECTION 10.49.(k) Not later than January 1, 2008, the Department of Health and Human Services shall complete the development of a Uniform Screening Tool (UST) to determine the mental health of any individual admitted to any long-term care facility. The Department shall report on the status of UST development on or before October 1, 2007, to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

SECTION 10.49.(l) G.S. 122C-115.4(b)(5) reads as rewritten:

"(b) The primary functions of an LME include all of the following:

(5) Care coordination and quality management. This function ~~includes the direct monitoring of the effectiveness of person centered plans. It also includes the initiation of and participation in the development of required modifications to the plans for high risk and high cost consumers in order to achieve better client outcomes or equivalent outcomes in a more cost-effective manner. Monitoring effectiveness includes reviewing client outcomes data supplied by the provider, direct contact with consumers, and review of consumer charts.~~involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination is sometimes referred to as "care management." Care coordination shall be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, when necessary to link clients to higher levels of care quickly and efficiently, to facilitate the resolution of disagreements between providers and clinicians, and to consult with providers, clinicians, case managers, and utilization reviewers. Care coordination activities for high risk/high cost consumers or consumers at a critical treatment juncture include the following:

a. Assisting with the development of a single care plan for individual clients, including participating in child and family teams around the development of plans for children and adolescents.

b. Addressing difficult situations for clients or providers.

c. Consulting with providers regarding difficult or unusual care situations.
d. Ensuring that consumers are linked to primary care providers to address the consumer's physical health needs.
e. Coordinating client transitions from one service to another.
f. Customer service interventions.
g. Assuring clients are given additional, fewer, or different services as client needs increase, lessen, or change.
h. Interfacing with utilization reviewers and case managers.
i. Providing leadership on the development and use of communication protocols.
j. Participating in the development of discharge plans for consumers being discharged from a State facility or other inpatient setting who have not been previously served in the community."

CRISIS AND ACUTE CARE SERVICES.

SECTION 10.49.(m) The thirteen million seven hundred thirty-seven thousand eight hundred fifty-six dollars ($13,737,856) appropriated in this act for crisis services in each fiscal year to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, shall be allocated to local management entities to continue to implement the crisis plans developed under S.L. 2006-66, Section 10.26. In allocating these funds, the Department shall consider the impact of the closure of any State institution on each local management entity. The Department of Health and Human Services may use up to two hundred fifty thousand dollars ($250,000) in each fiscal year of the funds allocated under this subsection to extend its contract with the crisis services consultant authorized under Section 10.26(b) of S.L. 2006-66.

SECTION 10.49.(n) S.L. 2006-66, Section 10.26(d), as amended by Section 11 of S.L. 2006-221, reads as rewritten:

"**SECTION 10.26.(d)** With the assistance of the consultant, the ~~area authorities and county programs~~ LMEs within a crisis region shall work together to identify gaps in their ability to provide a continuum of crisis services for all consumers and use the funds allocated to them to develop and implement a plan to address those needs. At a minimum, the plan must address the development over time of the following components: 24-hour crisis telephone lines, walk-in crisis services, mobile crisis outreach, crisis respite/residential services, crisis stabilization units, 23-hour beds, facility-based crisis, in-patient crisis, detox, and transportation. Options for voluntary admissions to a secured facility must include at least one service appropriate to address the mental health, developmental disability, and substance abuse needs of adults, and the mental health, developmental disability, and substance abuse needs of children. Options for involuntary commitment to a secured facility must include at least one option in addition to admission to a State facility.

If all ~~area authorities and county programs~~ LMEs in a crisis region determine that a facility-based crisis center is needed and sustainable on a long-term basis, the crisis region shall first attempt to secure those services through a community hospital or other community facility. If all ~~area authorities and county programs~~ LMEs in the crisis region determine the region's crisis needs are being met, the ~~area authorities and county programs~~ LMEs may use the funds to meet local crisis service needs."

SECTION 10.49.(o) LMEs shall report monthly to the Department and to the consultant regarding the use of the funds, whether there has been a reduction in the use of State psychiatric hospitals for acute admissions, and any remaining gaps in local and regional crisis services. The consultant and the Department shall report quarterly to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental

Health, Developmental Disabilities, and Substance Abuse Services regarding each LME's proposed and actual use of the funds appropriated under this section. The reporting requirements under this subsection shall expire July 1, 2008.

SECTION 10.49.(q) G.S. 122C-147.1 is amended by adding the following new subsection to read:

"(b1) Notwithstanding subsection (b) of this section, funds appropriated by the General Assembly for crisis services shall not be allocated in broad disability or age/disability categories. Subsection (c) of this section shall not apply to funds appropriated by the General Assembly for crisis services."

SECTION 10.49.(r) The Department of Health and Human Services shall develop a system for reporting to LMEs aggregate information regarding all visits to community hospital emergency departments due to a mental illness, a developmental disability, or a substance abuse disorder. The report shall be submitted on a quarterly basis beginning with the 2007-2008 fiscal year.

SECTION 10.49.(s1) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division), the sum of two million five hundred thousand dollars ($2,500,000) for the 2007-2008 fiscal year and the sum of five million dollars ($5,000,000) for the 2008-2009 fiscal year shall be used to develop a pilot program to reduce State psychiatric hospital use and to increase local services for persons with mental illness. Of these funds, the sum of two hundred fifty thousand dollars ($250,000) in each fiscal year shall be retained by the Department. The remainder in each fiscal year shall be allocated to LMEs to be used in accordance with this section. The Division and each selected LME shall implement an 18-month pilot beginning in the 2007-2008 fiscal year, as provided in subsections (s2) and (s3) of this section. It is the intent of the General Assembly to provide funds to expand the pilot program in the 2008-2009 fiscal year. To this end, the Division shall develop a plan for expanded pilots as provided in subsection (s4) of this section.

SECTION 10.49.(s2) The purpose of the 18-month pilot program developed under subsection (s1) of this section and to be implemented during the 2007-2008 fiscal year is to test a mechanism to reduce psychiatric hospital use by holding an LME financially and clinically responsible for the cost of that use and by providing additional resources to build community capacity. The Department shall select up to three LMEs in the same catchment area and at least one LME in a different catchment area that submit a proposal to participate in the pilot to the Division no later than October 15, 2007. The proposal shall include a plan by the LME to reduce hospital use by a specified amount and an explanation of how the LME expects to accomplish this goal. To facilitate pilot implementation, the Division shall do all of the following:

(1) Calculate the cost of each LME's 2006-2007 use of State psychiatric hospital services based roughly on that hospital's total budget and the percentage of patients at the hospital admitted from the LME's catchment area.

(2) Calculate a daily rate for hospital usage based on 2006-2007 statewide usage. The daily rate shall be higher for subsequent admissions by the same patient and higher for patients admitted with a primary diagnosis of substance abuse.

(3) Provide the results from subdivisions (1) and (2) of this subsection to all LMEs not later than September 1, 2007.

(4) Award pilot participation not later than November 1, 2007, based upon the proposals that project the largest decrease in use and that the Division believes has the greatest likelihood of succeeding.

(5) Commence pilot implementation not later than January 1, 2008.

SECTION 10.49.(s3) Parameters of the pilot developed under subsection (s1) of this section are as follows:

(1) The pilot LMEs will have a virtual budget account for January 1, 2008, through June 30, 2008, based on one-half of the LME's cost of State psychiatric hospital use during the 2006-2007 fiscal year minus the LME's proposed reduction in hospital use. The virtual budget account will be for the full amount less an agreed upon reduction in the second year of the pilot.

(2) Every bed day used by patients from that LME's catchment area will be debited against that LME's virtual account.

(3) The cost of bed days will increase by the agreed upon amount for patients who are repeatedly admitted to the hospital.

(4) The cost of bed days will increase by the agreed upon amount for patients who are admitted with a primary diagnosis of substance abuse.

(5) The LME shall have one or more representatives on site at the State psychiatric hospital. The LME representatives shall be involved with patient admissions, development of treatment plans, supervision and delivery of treatment, and development and implementation of discharge plans.

(6) The pilot LMEs shall use their allocated funds to: (i) build community capacity through start-up operations or payment for local services; (ii) pay for the on-site representative at State psychiatric hospitals; and (iii) pay for patient bed days that are in excess of RFP's projected use.

(7) Any funds remaining from the two million two hundred fifty thousand dollar ($2,250,000) allocation shall carry over to be used by the LMEs to pay for services to the mentally ill.

SECTION 10.49.(s4) Based on the experiences of the pilot programs authorized under subsections (s2) and (s3) of this section, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division) shall work with the existing hospital use study group to develop a proposal for subsequent pilots to reduce hospital use and build community services. The Division may use up to two hundred fifty thousand dollars ($250,000) in each fiscal year to develop the proposal. The Division shall submit an interim report on its progress to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (Oversight Committee) by October 15, 2007, and a second interim report by February 1, 2008. The Division shall submit its final report to the Oversight Committee by February 1, 2009. The final report shall include a description of the pilot LMEs' success in working with local hospitals and the resulting reductions in the use of emergency rooms, jails, and State facilities.

SECTION 10.49.(s5) The budgets for the State psychiatric hospitals shall not be reduced during the 2007-2008 fiscal year as a result of the pilot developed under subsection (s1) of this section. However, those budgets shall be adjusted in following years to reflect the previous year's use by the LMEs participating in the pilot program.

SECTION 10.49.(t) Notwithstanding G.S. 122C-112.1(a)(30) and G.S. 122C-181, the Secretary of Health and Human Services may close Dorothea Dix Hospital, and the Secretary of Health and Human Services may close John Umstead Hospital or any unit or section of that hospital, provided that all of the following conditions have been met prior to closure of each hospital or unit thereof:

(1) The Secretary has notified the Joint Legislative Commission on Governmental Operations, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and members of the General Assembly who represent catchment areas affected by the closure.

(2) The Secretary has presented a plan for the closure of each hospital or unit thereof to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (Oversight Committee) for its review, advice, and recommendations.

The Secretary shall also provide a copy of the plan to each member of the General Assembly in a timely manner to permit each member of the General Assembly to comment at the presentation of the plan to the Oversight Committee. The plan shall address specifically all of the following: (i) the capacity of any replacement facility and the catchment area to meet the needs of those consumers who require long-term secure services as well as acute care; (ii) an inventory of existing capacity in the communities within the catchment area for patients to access crisis services, appropriate housing, and other necessary supports; (iii) how the State and the LMEs in the catchment area will attract and retain qualified private providers that will provide services to State-paid non-Medicaid-eligible consumers; and (iv) the impact of the closure on remaining State facilities. In implementing the plan, the Secretary shall take into consideration the comments and recommendations of the Oversight Committee and other members of the General Assembly.

(3) The Central Regional Hospital is operational and patient transfers from Dorothea Dix Hospital and John Umstead Hospital have been completed.

(4) Notwithstanding any other provision of law, the Secretary shall not close a State facility if there are not adequate replacement services available prior to the date of closure.

SECTION 10.49.(u) In keeping with the United States Supreme Court decision in Olmstead v. L.C. & E.W. and State policy to provide appropriate services to clients in the least restrictive and most appropriate environment, the Department of Health and Human Services shall continue to implement a plan for the transition of patients from State psychiatric hospitals to the community or to other long-term care facilities, as appropriate. The goal is to develop mechanisms and identify resources needed to enable patients and their families to receive the necessary services and supports based on the following guiding principles:

(1) Individuals shall be provided acute psychiatric care in non-State facilities when appropriate.

(2) Individuals shall be provided acute psychiatric care in State facilities only when non-State facilities are unavailable.

(3) Individuals shall receive evidence-based psychiatric services and care that are cost-efficient.

(4) The State shall minimize cost shifting to other State and local facilities or institutions.

The Department of Health and Human Services shall conduct an analysis of the individual patient service needs and shall develop and implement an individual transition plan, as appropriate, for patients in each hospital. The State shall ensure that each individual transition plan, as appropriate, shall take into consideration the availability of appropriate alternative placements based on the needs of the patient and within resources available for the mental health, developmental disabilities, and substance abuse services system. In developing each plan, the Department shall consult with the patient and the patient's family or other legal representative.

The Department of Health and Human Services shall submit reports on the status of implementation of this section to the Joint Legislative Commission on Governmental Operations, the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division. These reports shall be submitted on December 1, 2007, and May 1, 2008.

USE OF MENTAL HEALTH TRUST FUNDS.

SECTION 10.49.(v) Funds in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs (Mental Health Trust Fund) that are designated by the Department of Health and Human Services in its 2006-2007 Mental Health Trust Fund Plan for increasing community-based services, shall be disbursed in full by the Department to LMEs for this purpose not later than October 1, 2007. Funds received by LMEs on or before October 1, 2007, for this purpose and not expended or encumbered by LMEs for this purpose by June 30, 2009, shall revert on that date to the Mental Health Trust Fund.

Notwithstanding G.S. 143C-9-2, as amended by subsection (w1) of this section, the Department of Health and Human Services may spend funds in the Mental Health Trust Fund for the 2007-2008 fiscal year for allowable purposes other than community-based programs provided that such purposes were included in the 2006-2007 Mental Health Trust Fund Plan. As used in this subsection "allowable purposes" means the statutory authorization in effect under G.S. 143-15.3D on June 30, 2007.

SECTION 10.49.(w1) G.S. 143C-9-2 reads as rewritten:

"**§ 143C-9-2. Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs.**

(a) The Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs is established as an interest-bearing, nonreverting special trust fund in the Office of State Budget and Management. Moneys in the Trust Fund shall be held in trust and used solely to increase community-based services that meet the mental health, developmental disabilities, and substance abuse services needs of the State. The Trust Fund shall be used to supplement and not to supplant or replace existing State and local funding available to meet the mental health, developmental disabilities, and substance abuse services needs of the State.

The State Treasurer shall hold the Trust Fund separate and apart from all other moneys, funds, and accounts. The State Treasurer shall be the custodian of the Trust Fund and shall invest its assets in accordance with G.S. 147-69.2 and G.S. 147-69.3. Investment earnings credited to the assets of the Trust Fund shall become part of the Trust Fund. Any balance remaining in the Trust Fund at the end of any fiscal year shall be carried forward in the Trust Fund for the next succeeding fiscal year.

Moneys in the Trust Fund shall be expended only in accordance with subsection (b) of this section and in accordance with limitations and directions enacted by the General Assembly.

(b) Moneys in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs shall be allocated to area programs to be used only to:

(1) Provide start-up funds and operating support for programs and services that provide more appropriate and cost-effective community treatment alternatives for individuals currently residing in the State's mental health, developmental disabilities, and substance abuse services institutions.

~~(2) Facilitate the State's compliance with the United States Supreme Court decision in Olmstead v. L.C. and E.W.~~

(3) Facilitate reform of the mental health, developmental disabilities, and substance abuse services system and expand and enhance treatment and prevention services in these program areas to remove waiting lists and provide appropriate and safe services for clients.

(4) Provide bridge funding to maintain appropriate client services during transitional periods as a result of facility closings, including departmental restructuring of services.

~~(5) Construct, repair, and renovate State mental health, developmental disabilities, and substance abuse services facilities.~~

(c) Notwithstanding G.S. 143C-1-2, any nonrecurring savings in State appropriations realized from the closure of any State psychiatric hospitals that are in excess of the cost of operating and maintaining a new State psychiatric hospital shall not revert to the General Fund but shall be placed in the Trust Fund and shall be used for the purposes authorized in this section. Notwithstanding G.S. 143C-1-2, recurring savings realized from the closure of any State psychiatric hospitals shall not revert to the General Fund but shall be credited to the Department of Health and Human Services to be used only for the purposes of subsections (b)(1) ~~(b)(2)~~ and (b)(3) of this section.

(d) Beginning July 1, 2007, the Secretary of the Department of Health and Human Services shall report annually to the Fiscal Research Division on the expenditures made during the preceding fiscal year from the Trust Fund. The report shall identify each expenditure by recipient and purpose and shall indicate the authority under subsection (b) of this section for the expenditure."

SECTION 10.49.(w2) Notwithstanding G.S. 143C-9-2(c), additional savings in the 2007-2008 and 2008-2009 fiscal years shall be used to fund the State's contribution for local management entity system administration.

SECTION 10.49.(w3) Notwithstanding G.S. 143C-9-2(b) requiring allocation of funds to area programs, the Department of Health and Human Services may use up to one million five hundred thousand dollars ($1,500,000) in each of the 2007-2008 and 2008-2009 fiscal years from the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs for the purposes authorized under G.S. 143C-9-2(b)(1), (3), and (4).

SECTION 10.49.(x) Notwithstanding G.S. 143C-9-2, as amended by this act, the Secretary of Health and Human Services may use funds for the 2007-2008 fiscal year from the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs (Trust Fund) or, if funds in the Trust Fund are insufficient, from other available sources in the Department of Health and Human Services, to support up to 66 new positions in the Julian F. Keith Alcohol and Drug Abuse Treatment Center, provided that these funds may be used only if the Julian F. Keith Alcohol and Drug Abuse Treatment Center opens before July 1, 2008.

STRENGTHEN THE SERVICES NETWORK.

SECTION 10.49.(y) Not later than September 1, 2007, the Department of Health and Human Services shall designate two additional local management entities to receive all State allocations through single stream funding. The Department shall develop clear standards for how an LME qualifies for single stream funding and shall award single stream funding to any other LME that meets those standards within the 2007-2008 and 2008-2009 fiscal years. These standards shall be developed and implemented not later than October 1, 2007. In addition to the LMEs designated by the Department, the Piedmont, New River, Smoky Mountain, Guilford, Sandhills, Five County, and Mecklenburg LMEs shall continue to receive State allocations through single stream funding. The Department may adopt temporary rules in accordance with Chapter 150B of the General Statutes in order to implement the standards required by this subsection by October 1, 2007.

SECTION 10.49.(z) The Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities, and Substance Abuse Services shall study the effectiveness of the 1915(b) Medicaid waiver and of those LMEs operating under a waiver.

SECTION 10.49.(z1) The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) shall study whether and under what circumstances it would be appropriate for an LME to be a service provider. The LOC shall report its findings in its report to the 2008 Regular Session of the 2007 General Assembly.

SECTION 10.49.(aa) No later than July 1, 2008, the Department of Health and Human Services shall commence the process for three additional local management entities to apply for Medicaid waivers.

FILLING SERVICE GAPS.

SECTION 10.49.(bb) Funds appropriated in this act for mental health services and supported employment shall be allocated to local management entities such that each local management entity receives a percentage of the total allocation that is equal to that local management entity's percentage of the State's total population that is below the federal poverty level. Funds appropriated to the Department of Health and Human Services for the 2006-2007 fiscal year for mental health services, substance abuse services, and crisis services and allocated based on the poverty level shall continue to be allocated by the Department to local management entities such that each local management entity receives a percentage of the total allocation that is equal to that local management entity's percentage of the State's total population that is below the federal poverty level.

SECTION 10.49.(cc) G.S. 122C-147.1(c) shall apply to the State-funded service of developmental therapies.

SECTION 10.49.(dd) The Department of Health and Human Services shall develop and apply to the Centers for Medicare and Medicaid Services for additional home and community-based waivers for persons with developmental disabilities. In conjunction with the existing CAP MR/DD waiver, the new waivers will create a tiered system of services. Not later than March 1, 2008, the Department shall report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the status of the waivers required under this section.

SECTION 10.49.(ee) For the purpose of avoiding overutilization of community support services and overexpenditure of funds for these services, the Department of Health and Human Services shall immediately conduct an in-depth evaluation of the use and cost of community support services to identify existing and potential areas of overutilization and overexpenditure. The Department shall also adopt or revise as necessary management policies and practices that will ensure that at a minimum:

(1) There is in place a list of community support services that are appropriate to meet the critical needs of the client and are cost effective;

(2) Community support services are appropriately utilized based on the critical needs of the client, and utilization is monitored routinely to ensure against overutilization;

(3) That expenditures for services are controlled to the maximum extent possible without unnecessarily impairing service quality and efficiency;

(4) Service providers are fully competent to provide each service, to provide the service in the most efficient manner, and that services and providers meet standards of protocol adopted by the Department. To this end, endorsement shall be based on compliance with: a Medicaid service-specific checklist, rules for Mental Health, Developmental Disabilities, and Substance Abuse Services, client rights rules in community Mental Health, Developmental Disabilities, and Substance Abuse Services, the Medicaid service records manual, and other Medicaid requirements as stipulated in the participation agreement with the Division of Medical Assistance. In accordance with G.S. 122C-115.4, an LME may remove a provider's endorsement;

(5) All community support services are subject to prior approval after the initial assessment and development of a person-centered plan has been completed;

(6) Providers are limited to four hours of community support for adults and eight hours of community support for children to develop the person-centered plan. Those hours shall be provided only by a qualified professional. Providers that determine that additional hours are needed must seek and obtain prior approval. If additional hours are authorized, the LME may participate in the development of the person-centered plan as part of its care coordination and quality management function as defined in G.S. 122C-115.4.

(7) Based on standards of care and practice, a stringent clinical review process for authorization of services is implemented uniformly and in accordance with State guidelines;

(8) Additional record audits of providers are conducted on a routine basis to continually ensure compliance with Medicaid requirements;

(9) Post-payment clinical reviews are conducted at the local level to ensure that consumers receive the appropriate level and intensity of care;

(10) Beginning October 1, 2007, and monthly thereafter, report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include the following:

a. The number of consumers of community support services by month, segregated by adult and child;

b. The number of units of community support services billed and paid by month, segregated by adult and child;

c. The amount paid for community support by month, segregated by adult and child;

d. Of the numbers provided in sub-subdivision b. of this subdivision, identify those units provided by a qualified professional and those provided by a paraprofessional;

e. The length of stay in community support, segregated by adult and child;

f. The number of clinical post payment reviews conducted by LMEs and a summary of those findings;

g. The total number of community support providers and the number of newly enrolled, re-enrolled, or terminated providers, and if available, reasons for termination;

h. The number of community support providers that have been referred to DMA's Program Integrity Section, the Division's "Rapid Action response" committee; or the Attorney General's Office;

i. The utilization of other, newly enhanced mental health services, including the number of consumers served by month, the number of hours billed and paid by month, and the amount expended by month;

(11) If possible, modify the Medicaid claims payment processing system so that providers will be required to identify, by claim, whether the service was provided by a qualified professional or a paraprofessional; and

(12) The Department of Health and Human Services and the Department of Public Instruction shall amend their Memorandum of Agreement to ensure that each local education agency develops its own list of approved providers and individual service providers authorized to

provide services on campus as provided under the Federal Safe Schools Act.

The Department shall report not later than November 1, 2007, on the list of community support services determined to be appropriate. Not later than March 1, 2008, the Department shall provide a detailed report on the implementation and status of each of the activities required by this subsection to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division. The report shall also include clear standards for determining local management entity capability to perform utilization review and utilization management and clear statewide standards for utilization review and utilization management. These standards shall include (i) determination of medical necessity; (ii) an authorization process that includes the use of standardized forms; (iii) concurrent review procedures; (iv) recipient appeals process; (v) minimum staffing requirements; (vi) requirements for data collection and reporting; and (vi) performance criteria for the LMEs and outside vendor.

In order to ensure full compliance with the laws of this State on the implementation of mental health reform, the Department shall, by January 1, 2008, adopt statewide standardized authorization procedures and processes for Medicaid utilization review. Before July 1, 2008, (i) up to six LMEs that meet those standards (not including LMEs approved for 1915(b) waivers) may, under contract with the outside vendor, complete the utilization review process for enhanced benefit and CAP MR/DD services for the LMEs' respective catchment areas; (ii) the Department shall have a process outlined that would enable all other LMEs to meet the standards required for completing the utilization review process under contract with the outside vendor; (iii) the Department shall report on the implementation of utilization review, including the utilization review process, subcontract details, and funding levels, to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division. The Department shall ensure that all Medicaid utilization review contracts with outside vendors, as required under this subsection, that are executed, renewed, or extended after the effective date of this act, are in compliance with and do not impair, interfere with, or otherwise prohibit the implementation of this subsection. Prior to renewing, extending, or entering into a contract with an outside vendor for utilization review under this subsection, the Department shall consult with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

LME ADMINISTRATIVE FUNDING.

SECTION 10.49.(ff) The General Assembly finds that counties have budgeted almost one hundred twenty-one million dollars ($121,000,000) to LMEs to pay for mental health, developmental disabilities, and substance abuse services. However, the General Assembly lacks information regarding the specific services that are purchased with those county funds. The General Assembly also lacks data regarding the incomes of persons receiving mental health, developmental disabilities, and substance abuse services that are paid for by either State or county funds. This lack of data severely limits the General Assembly's ability to determine the distribution of services that are being paid for with public funds, whether persons who are eligible for Medicaid are being enrolled in that program, and whether expanding the State's Medicaid eligibility criteria would impact a significant number of mental health, developmental disabilities, and substance abuse services consumers. Therefore, LMEs shall report annually to the Division all expenditures from county funds by the LME for services, start-up expenses, and capital and operational expenditures, regardless of the

source of the funds and regardless of whether the funds were earned on a payment for service or grant basis. This reporting shall include specific information regarding the expenditure of all funds provided to the LME by the county or counties contained in the LME's catchment area and the amount of expenditures for services provided by the multicounty LME to residents of each county in the multicounty LME's catchment area. To the extent possible, the information shall be submitted through the Integrated Payment and Reimbursement System. LMEs shall also gather income data for all individuals receiving services. Notwithstanding G.S. 143C-6-4, Budget Adjustments Authorized, the Department of Health and Human Services shall fully fund the State's contribution for LME system administration.

SECTION 10.49.(gg) It is the intent of the General Assembly that the deficit in State funding for local management entity system administration will be eliminated in future years through savings from hospital downsizing. The General Assembly anticipates that full funding for this purpose will be available in the 2009-2011 fiscal biennium.

SECTION 10.49.(hh) G.S. 122C-115.4(d) reads as rewritten:

"(d) Except as provided in G.S. 122C-142.1 and G.S. 122C-125, the Secretary may ~~not~~ neither remove from an LME nor designate another entity as eligible to implement any function enumerated under subsection (b) of this section unless all of the following applies:

(1) The LME fails during the previous three months to achieve a satisfactory outcome on any of the critical performance measures developed by the Secretary under G.S. 122C-112.1(33).

(2) The Secretary provides focused technical assistance to the LME in the implementation of the function. The assistance shall continue for at least six months or until the LME achieves a satisfactory outcome on the performance measure, whichever occurs first.

(3) If, after six months of receiving technical assistance from the Secretary, the LME still fails to achieve or maintain a satisfactory outcome on the critical performance measure, the Secretary shall enter into a contract with another LME or agency to implement the function on behalf of the LME from which the function has been removed."

SECTION 10.49.(ii) The Department of Health and Human Services shall use available funds not to exceed five hundred thousand dollars ($500,000) in each fiscal year to contract with the University of North Carolina at Chapel Hill, Kenan Flagler Business School, to provide administrative training to local management entities. The Department of Health and Human Services shall advise the Kenan Flagler Business School on prioritizing those local management entities that would most benefit from the training. The Department of Health and Human Services shall use funds available for the contract.

SECTION 10.49.(jj) In allocating funds from existing resources to local management entities for administrative costs, the Department shall ensure that each local management entity receives not less in service dollars than that local management entity expensed for services in the 2006-2007 fiscal year.

DEVELOPMENTAL CENTER DOWNSIZING

SECTION 10.50.(a) In accordance with the Department of Health and Human Services' plan for mental health, developmental disabilities, and substance abuse services system reform, the Department shall ensure that the downsizing of the State's Developmental Centers is based upon individual needs and the availability of community-based services with a targeted goal of four percent (4%) each year. The Department shall implement cost-containment and reduction strategies to ensure the corresponding financial and staff downsizing of each facility. The Department shall manage the client population of the Developmental Centers in order to ensure that placements for ICF-MR level of care shall be made to appropriate community-based

settings. Admissions to a State-operated ICF-MR facility is permitted only as a last resort and only upon approval of the Department. The corresponding budgets for each of the Developmental Centers shall be reduced, and positions shall be eliminated as the census of each facility decreases in accordance with the Department's budget reduction formula. At no time shall mental retardation center positions be transferred to other units within a facility or assigned nondirect care activities such as outreach.

SECTION 10.50.(b) The Department of Health and Human Services shall apply any savings in State appropriations in each year of the 2007-2009 biennium that result from reductions in beds or services as follows:

(1) The Department shall place nonrecurring savings in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs and use the savings to facilitate the transition of clients into appropriate community-based services and support in accordance with G.S. 143C-9-2;

(2) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall retain recurring savings realized through implementation of this section to support the recurring costs of additional community-based placements from Division facilities in accordance with Olmstead v. L.C. & E.W. In determining the savings in this section, savings shall include all savings realized from the downsizing of the Developmental Centers, including the savings in direct State appropriations in the budgets of the Developmental Centers; and

(3) The Department of Health and Human Services, Division of Medical Assistance, shall transfer any recurring Medicaid savings resulting from the downsizing of State-operated Developmental Centers from the ICF-MR line in Medicaid to support Medicaid services to assist in continued community service opportunities for people with developmental disabilities.

SECTION 10.50.(c) Consistent with the requirements of this section, the Secretary of Health and Human Services shall update the existing plan to ensure that there are sufficient developmental disability/mental retardation regional centers to correspond with service catchment areas. The plan shall address:

(1) Methods of funding for community services necessitated by downsizing;

(2) How many State-operated beds and non-State-operated beds are needed to serve the population; and

(3) Alternative uses for facilities.

Not later than April 1, 2008, the Department shall provide an updated report on the development of the plan, and not later than April 1, 2009, shall report the final plan, including recommendations for legislative action, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 10.50.(d) The Department of Health and Human Services shall provide an updated report on its progress in complying with this section to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division. The Department shall submit the progress report no later than January 15, 2008, and submit a final report no later than May 1, 2009.

DHHS POLICIES AND PROCEDURES IN DELIVERING COMMUNITY MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

SECTION 10.51.(a) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall in cooperation with area mental health authorities and county programs, identify and eliminate administrative and fiscal barriers created by existing State and local policies and procedures in the delivery of community-based mental health, developmental disabilities, and substance abuse services provided through the area programs and county programs, including services provided through the Comprehensive Treatment Services Program for Children and services delivered to multiply diagnosed adults. The Department shall implement changes in policies and procedures in order to facilitate all of the following:

(1) The provision of services to adults and children as defined in the Mental Health System Reform State Plan as priority or targeted populations.

(2) The provision of services to children not deemed eligible for the Comprehensive Treatment Services Program for Children, but who would otherwise be in need of medically necessary treatment services to prevent out-of-home placement.

(3) The provision of services in the community to adults remaining in and being placed in State institutions addressed in Olmstead v. L.C.

SECTION 10.51.(b) The Department shall rework the revised system of allocating State and federal funds to area mental health authorities and county programs to better reflect projected needs, including the impact of system reform efforts rather than historical allocation practices and spending patterns. The reworked allocation shall include the following:

(1) For each LME, the current allocation by source and age/disability category, and the newly proposed allocation by source and age/disability category;

(2) A clear formula for how the new allocations are derived with a detailed methodology for how the formula was created; and

(3) A plan for moving to the new formula.

The Department shall submit the reworked language to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division not later than October 1, 2007, for review. The Department shall implement the system only after review and approval by the 2007 General Assembly, Regular Session 2008.

SECTION 10.51.(c) Area mental health, developmental disabilities, and substance abuse services authorities and county programs shall use all funds appropriated for and necessary to provide mental health, developmental disabilities, and substance abuse services to meet the need for these services. If excess funds are available after expending appropriated funds to fully meet service needs, one-half of these excess funds shall not revert to the General Fund but shall be transferred to the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs, except that one-half of the funds appropriated for the Comprehensive Treatment Services Program for Children that are unexpended and unencumbered shall not revert to the General Fund but shall be carried forward and used only for services for children and adolescents.

The Department, in consultation with the area mental health authorities and county programs, shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the progress in implementing these changes. The report shall be submitted on October 1, 2007, and February 1, 2008.

SERVICES TO MULTIPLY DIAGNOSED ADULTS

SECTION 10.52.(a) In order to ensure that multiply diagnosed adults are appropriately served by the mental health, developmental disabilities, and substance abuse services system, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall do the following with respect to services provided to these adults:

(1) Implement the following guiding principles for the provision of services:
   a. Service delivery system must be outcome-oriented and evaluation-based.
   b. Services should be delivered as close as possible to the consumer's home.
   c. Services selected should be those that are most efficient in terms of cost and effectiveness.
   d. Services should not be provided solely for the convenience of the provider or the client.
   e. Families and consumers should be involved in decision making throughout treatment planning and delivery.

(2) Provide those treatment services that are medically necessary.

(3) Implement utilization review of services provided.

SECTION 10.52.(b) The Department of Health and Human Services shall implement all of the following cost-reduction strategies:

(1) Preauthorization for all services except emergency services.

(2) Criteria for determining medical necessity.

(3) Clinically appropriate services.

SECTION 10.52.(c) No State funds shall be used for the purchase of single-family or other residential dwellings to house multiply diagnosed adults.

SECTION 10.52.(d) The Department shall report on implementation of this section on May 1, 2008, and again on May 1, 2009, to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division.

DEPARTMENTAL FLEXIBILITY IN SCHEDULING THE TRANSFER OF POSITIONS PERTAINING TO THE CLOSURE OF DOROTHEA DIX AND JOHN UMSTEAD HOSPITALS AND THE OPENING OF CENTRAL REGIONAL HOSPITAL

SECTION 10.53.(a) The Department of Health and Human Services may schedule the transfer of positions relating to the closure of Dorothea Dix Hospital and John Umstead Hospital and the opening of Central Regional Hospital in accordance with appropriations and reductions in funding enacted in this act in a manner that is timely and with minimal disruption in services. The Department may not transfer more positions than are authorized in the House of Representatives Appropriations Committee Report on Health and Human Services, referenced in this act, for the closure of Dorothea Dix Hospital and John Umstead Hospital, the opening of Central Regional Hospital, the transfer of Whitaker School and R. J. Blackley ADATC to Central Regional Hospital, and the transfer of Dorothea Dix Hospital Forensic Unit beds to Broughton Hospital.

SECTION 10.53.(b) Of the funds appropriated in this act to the Department of Health and Human Services for Broughton Hospital, the sum of up to two hundred fifty thousand dollars ($250,000) may be used by Broughton Hospital to purchase a CT Scanner.

INSTITUTE OF MEDICINE TASK FORCE/STUDY OF SUBSTANCE ABUSE SERVICES IN NORTH CAROLINA

SECTION 10.53A.(a) The three hundred thousand dollars ($300,000) appropriated in this act to the Department of Health and Human Services for allocation to the North Carolina Institute of Medicine (NC IOM) shall be used by the IOM to hire new staff, to undertake additional studies annually at the request of the General Assembly, and to support a rapid-response capacity to analyze secondary data sources on health or health-related data to the General Assembly and to State and local government agencies.

SECTION 10.53A.(b) The North Carolina Institute of Medicine shall use a portion of the funds allocated to it in subsection (a) of this section to convene a task force to study substance abuse services in North Carolina. The NC IOM shall provide staff and arrange for meeting facilities for the Task Force.

SECTION 10.53A.(c) The Task Force shall include the following:

(1) Members of the North Carolina Senate and the North Carolina House of Representatives. Senate members shall be appointed by the President Pro Tempore of the Senate. Members of the House of Representatives shall be appointed by the Speaker of the House of Representatives.

(2) Representatives of the North Carolina Department of Health and Human Services, local management entities, the North Carolina Department of Justice, the NC Office of the Attorney General, the North Carolina Community College System, and the North Carolina Department of Public Instruction.

(3) Providers of substance abuse services, academics and researchers with substance abuse expertise, local governmental agencies, business and industry, domestic violence organizations, consumer and family members, and other interested members of the public.

The IOM shall appoint as cochairs of the Task Force one member of the North Carolina House of Representatives, one member of the North Carolina Senate, and one member who provides substance abuse services selected from the Task Force.

SECTION 10.53A.(d) The Task Force shall:

(1) Identify the continuum of services needed for treatment of substance abuse services, including, but not limited to, prevention, outpatient services, residential treatment, and recovery supports. The Task Force shall examine what public and private organizations currently provide services, where services are offered, and gaps in the current service delivery system. The Task Force shall examine services that are available through public and private systems, but shall focus on the availability of substance abuse services through the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and local management entities. The Task Force shall identify which services should be available locally throughout the State, and which services should be offered regionally or statewide.

(2) Identify evidence-based models of care or promising practices in coordination with the NC Practice Improvement Collaborative for the prevention and treatment of substance abuse and develop recommendations to incorporate these models into the current substance abuse service system of care.

(3) Examine different financing options to pay for substance abuse services at the local, regional, and State levels. The Task Force shall also consider different reimbursement methodology, including, but not limited to, fee-for-service, grant funding, case rates, and capitation.

(4) Examine the adequacy of the current and future substance abuse workforce, including, but not limited to, credentialed substance abuse

counselors, availability of substance abuse workers throughout the State, and reimbursement levels. The Task Force shall develop a workforce education plan, if needed, to address current or future workforce shortages.

(5) Develop strategies to identify people in need of substance abuse services, including people who are dually diagnosed as having mental health and substance abuse problems. In addition, the Task Force shall examine strategies for providing substance abuse services to people with substance abuse problems identified through the State hospitals, and the judicial and social services systems.

(6) Examine barriers that people with substance abuse problems have in accessing publicly funded substance abuse services and explore possible strategies for improving access.

(7) Examine current outcome measures and identify other appropriate outcome measures to assess the effectiveness of substance abuse services, if necessary.

(8) Examine the economic impact of substance abuse in North Carolina. If data are available, the Task Force shall estimate the impact of substance abuse on the court system, health care system (e.g., through preventable hospitalizations), social services, and worker productivity.

(9) Make recommendations on the implementation of a cost-effective plan for prevention, early screening, diagnosis, and treatment of North Carolinians with substance abuse problems. In so doing, the Task Force shall identify any policy changes needed to implement the plan and develop cost estimates associated with different recommendations. The Task Force shall also examine existing public and private financing options and explore how existing funding could be used more effectively to pay for the recommended services.

SECTION 10.53A.(e) The North Carolina Institute of Medicine's Substance Abuse Services Task Force shall submit its interim report and recommendations to the 2008 General Assembly upon its convening and to the chairs of the Senate Health Committee, the House of Representatives Health Committee, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Governor. The final report shall be submitted no later than the convening of the 2009 General Assembly. Upon submission of this report, the Task Force shall terminate.

FUNDS FOR HEALTH CARE PERSONNEL REGISTRY AND FOR RATED CERTIFICATES FOR ADULT CARE HOMES/CONTINGENCY

SECTION 10.54.(a) Funds appropriated in this act to the Department of Health and Human Services, Division of Health Service Regulation, for the 2007-2008 fiscal year and the 2008-2009 fiscal year for positions and related costs to expand the Health Care Personnel Registry are contingent upon enactment of Senate Bill 56, 2007 Regular Session, by the 2007 General Assembly.

SECTION 10.54.(b) Funds appropriated in this act to the Department of Health and Human Services, Division of Health Service Regulation, for the 2007-2008 fiscal year and the 2008-2009 fiscal year for implementation of rated certificates for adult care homes are contingent upon enactment of Senate Bill 56, 2007 Regular Session, by the 2007 General Assembly.

DHHS BLOCK GRANTS

SECTION 10.55.(a) Appropriations from federal block grant funds are made for the fiscal year ending June 30, 2008, according to the following schedule:

TEMPORARY ASSISTANCE TO NEEDY FAMILIES